Chapter 30

THE IMPACT OF DEPLOYMENT ON MILITARY FAMILIES AND CHILDREN

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INTRODUCTION

"Deployment" is the term used when military personnel leave their usual daily workstations to train for or to perform a mission. Missions vary in length and range from training to humanitarian assistance to combat. Deployment has an effect on the service member, the member's unit, the units that remain to carry on with existing tasks, and the affiliated support systems in the community as well as the member's family. With an increased number of married military service members, deployment affects a growing community of spouses and children, both on and off base. Whether service members are single or married, their parents, siblings, and other relatives are frequently part of an extended family network that is affected by deployment and its outcome. This chapter addresses the complex issues faced by the military family when a service member leaves the home base to perform the mission of war. It also provides a list of resources available to military service members and their families (see Attachment).

In 1994, Peebles-Kleiger and Kleiger[1] wrote about reintegration stress in families with members returning from Operations Desert Shield/Storm (ODS/S). They described two versions of this stress: (1) Logan's seven phases of adjustment and (2) a four-stage version of emotional adjustment based on the Kubler-Ross model of grief.[1(pp176–177)] In a report on the emotional cycle of deployment following the Gulf War and during the rotations to Bosnia and Kosovo, Pincus et al[2] utilized these models to identify five stages: (1) predeployment, (2) deployment, (3) sustainment, (4) late deployment (referred to as "redeployment" in the original online article), and (5) postdeployment. Simon Pincus, MD, is an Army psychiatrist at McChord Medical Clinic (Madigan Army Medical Center) in Tacoma, Washington. He and his colleagues have continued using this approach as they educate families and communities during Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation Noble Eagle (ONE) engagements. Their goal is to sustain health and function in all family members during the stress of deployment.

In ODS/S (1990–1991), 645,000 troops were deployed to the war zone, including 228,000 National Guard and reserve forces that were brought onto active duty.[3(p273)] OIF and OEF have included an even wider variety and greater number of military service members[4(p233)]: activated reserve and National Guard units and personnel, as well as individual augmentees and ready reserve personnel. During the Balkans engagements service members were occasionally sent on second deployments and multiple tours (some units have had three or four deployments). Longer tours (particularly for the Army) to a combat theater have become common during OIF and OEF. Soldiers who have already endured physical and psychological injuries—including posttraumatic stress disorder (PTSD)—are being returned to combat conditions. The broader involvement of service personnel, who are deployed more frequently and for longer tours of duty, likely increases the impact of the mission on military as well as civilian families and communities.

In many cases during ODS/S, families were less prepared for mobilization and war[5(p442)] than families in today's readiness climate. Many families of ODS/S military personnel were unfamiliar with the larger military system of demands, benefits, and supports that exists for the active duty member and beneficiary. Foreign-born or non-English–speaking spouses, another subset of military families facing unique circumstances, may be less capable or willing to access available resources.[6(p78)]

School enrollment records provide one example of the size of deployment impact on military children. In 2004, Lamberg[7] reported in the *Journal of the American Medical Association* that 191,000 children of soldiers were enrolled in public schools in approximately 35 school districts near military posts around the United States. In addition to this number, the Department of Defense reported approximately 104,000 children enrolled in preschool through 12th grade at DoD schools in seven US states, Guam, and Puerto Rico, and in 13 foreign countries.[7]

To date, national and local community support of troops has been consistently positive in OIF, OEF, and ONE. Although there are differing political views and increasing criticism about the execution of the war in Iraq, the nation as a whole has been able to separate these issues from the role of military service members and to convey support for them and their families. This broad community support creates a positive environment for military families, which in turn results in less isolation and greater overall family resiliency.[8(p1285)]

THE DEPLOYMENT CYCLE

Each stage of deployment involves emotional and organizational elements that affect both individual service members and their families (Figure 30-1). Any impending deployment introduces uncertainty, even for previously deployed and experienced service members. Despite ongoing training, ambiguity likely exists

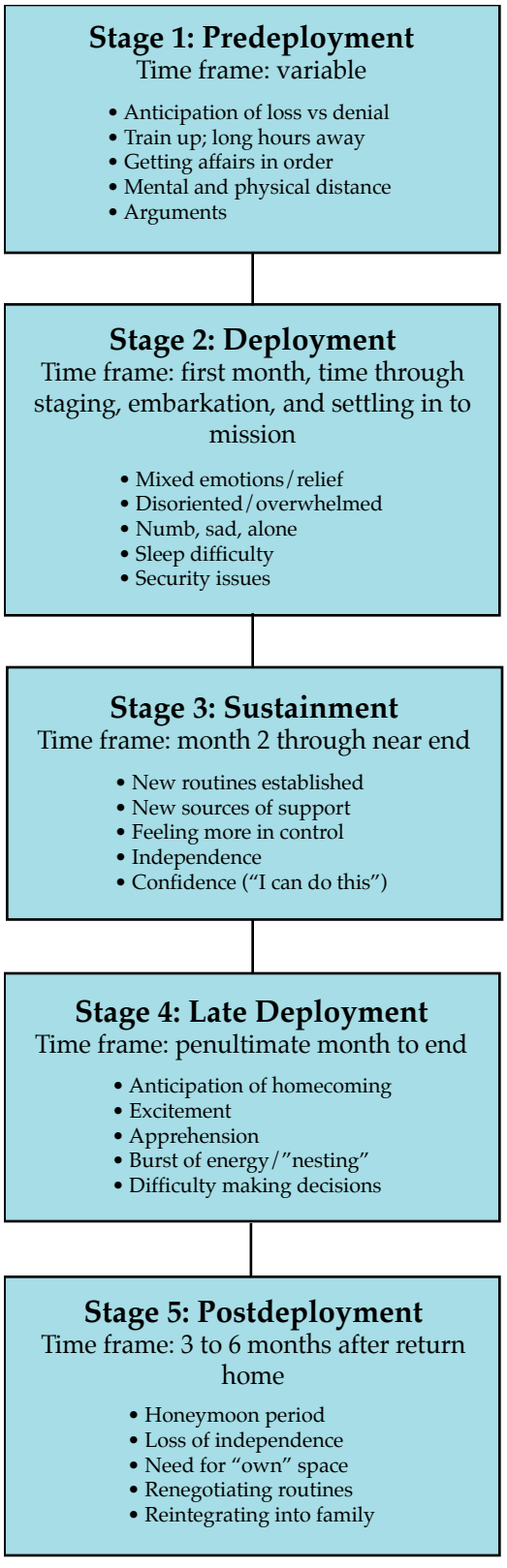

Figure 30-1. Common emotional rections to each stage of deployment.

TABLE 30-1

NEGATIVE EMOTIONAL AND BEHAVIORAL CHANGES IN CHILDREN DURING DEPLOYMENT

Age	Behaviors	Emotions	Remedies
Infants: < 1 y	Refusing to eat	Listlessness	Support from parent, pediatrician
Toddlers: 1–3 y	Crying, tantrums	Irritability, sadness	Increased attention, holding, hugs
Preschoolers: 3–6 y	Potty accidents, clinginess	Irritability, sadness	Increased attention, holding, hugs
School-age children: 6–12 y	Whining, body aches	Irritability, sadness	Spending time, maintaining routines
Teenagers: 12–18 y	Isolating, acting out, using drugs	Anger, apathy	Patience, limit-setting, counseling

about extent of the deployment, associated mission challenges, time commitment, the family's capacity to manage the separation, and the ever-present risk of injury or death.[3(p273),8(p1285)] The stages of military deployment are listed in Table 30-1 and discussed below. The model developed by Pincus, revised to accommodate current deployment cycles during OIF, OEF, and ONE, is the source for the following section.[9]

Predeployment

The *predeployment phase* starts with the alert order for deployment and ends when the service members leave the home station. Its time frame can vary from several weeks to more than a year. The predeployment period often results in both denial and anticipation of separation. For many, the predominant feeling is loss of control.[10(p632)] As the departure date approaches, spouses often ask if the service members really must go. Increased field training, preparation, and long hours away from home mark the beginning of the pending extended separation.

As service members think and talk about the upcoming mission and their unit relationships, bonding with fellow unit members is essential to unit cohesion and safety during the mission, but it can create an increasing sense of emotional and physical distance for military spouses and children.[9,11,12] Because of this psychological distancing, spouses often feel as

if their loved ones have already deployed. However, the change in focus from family to unit is a necessary part of the deployment process for active duty service members as they prepare for, and embrace, the mission. It can be especially demanding for the activated National Guard or Reserve service members who are transitioning from civilian to military life. By extension, spouses of National Guard and Reserve service members can have significant adjustment challenges during this transition. These complex issues can increase the individual service member's negative feelings within the context of deployment.[13(p633)]

With deployment pending, families review their personal and family affairs to reorder their lives during the service member's absence. Lists are generated to categorize a variety of expected needs: home repairs, home security, car maintenance, finances, insurance, tax preparation, childcare plans, and wills. Anxiety about financial and bill-paying responsibilities is often significant.[14(p85)] Couples may want increased intimacy and arrange for memorable holidays or anniversaries. Desire for sexual intimacy may be ambivalent, vacillating between wanting and not wanting to be close before the impending separation. Fears about marital fidelity may be raised or may go unspoken. Other frequently voiced concerns include anxiety about children's ability to handle the separation, fears of functioning without the partner, and the survivability of the marriage. Completing the multitude of tasks and fulfilling high expectations before deployment can place tremendous strain on couples and families.

It is not uncommon for military couples to argue before deployment.[3,9] For well-established couples and those familiar with the deployment cycle, arguments may be accepted as part of the rhythm of marital life and adjustment to deployment. For less experienced couples, however, especially those facing an extended separation for the first time, such arguments can lead to fears that the relationship could be over.

In 1980, Valentine cited the work of Evelyn Duvall, who identified "nine ever-changing family developmental tasks that span the life cycle."[15(p350)] These tasks serve to establish and maintain (1) an independent home, (2) satisfactory ways of obtaining and spending money, (3) mutually acceptable patterns in the division of labor, (4) continuity of mutually satisfying sexual relationships, (5) an open system of emotional and intellectual communication, (6) workable relationships with relatives, (7) ways of interacting with associates and the community, (8) competency in bearing and rearing children, and (9) a workable philosophy of life.[15(p350)]

Unresolved family challenges have potentially devastating consequences. To a military commander, a worried, preoccupied service member is easily distracted and unable to focus on essential tasks during critical times. From a psychological perspective, it is easier to be angry than to confront the pain and loss of saying goodbye.[2,16] In the worst-case scenario, unresolved emotional preoccupation can lead to serious accidents or the development of a combat stress disorder, which in turn can contribute to mission ineffectiveness.[17–19] At home, significant spousal distress interferes with completing basic routines, concentrating at work, and attending to the children. This can exacerbate children's fears that the parents are unable to adequately care for them or that the deployed parent will not return. Adverse child reactions include regressive behaviors such as inconsolable crying, apathy, or tantrums. A downward emotional spiral can result in which both service member and spouse become even more upset at the prospect of separating.

Kiser et al[20(p90)] outline seven characteristics of family resiliency: (1) a strong commitment to the family that involves a close bond and stable relationship with at least one person, (2) family organization with shared parental leadership and clear role boundaries, (3) belief in the family and its ability to succeed, (4) implementation of strategies to manage the demands created by stressors, (5) willingness to work to resolve issues, (6) maintenance of social connections, and (7) a coherent and positive understanding of stressors consistent with the family's shared world view.[20(p90)] When military couples are able to explore and discuss their mutual expectations as they prepare for the deployment, they are more likely to successfully adjust throughout the phases of the deployment experience. Healthy couples will expect that nondeploying spouses will exercise their freedom to make independent decisions; maintain contact with same- and opposite-sex friends and neighbors (for assistance and socialization); budget effectively; care for children competently; and stay in touch through letters, care packages, e-mail messaging, and telephone calls. Failure to communicate these and other expectations is frequently a source of misperception, distortion, and hurt feelings during and after the deployment period.

Deployment Phase

The *deployment phase* is the period from the service member's departure from home through the first month of separation. Mixed emotions arise during this stage. Spouses may report feeling disoriented or overwhelmed, or they may feel relieved that they no longer have to appear brave and strong. There may be residual anger about tasks left undone by the deployed spouse. The departure creates a gap that can lead to

feelings of numbness, sadness, loneliness, or abandonment. It is common for family members to have difficulty sleeping or coping with everyday challenges. Worries about home security and personal safety may come up again. Other concerns may involve pay problems, sick children, or car repairs. For many, the early part of the deployment stage can be an unpleasant, disorganizing experience.

Although it is often assumed that only wives have such difficulties or concerns, these issues apply to spouses of either gender. Husbands may feel overwhelmed in taking responsibility for childcare, school attendance and homework, meals and shopping, medical and dental care, extracurricular activities, peer groups, friends, and social activities for their children. When new caregivers are brought in to assist families in the absence of the deployed parent, feelings of uncertainty can develop in children as they attempt to integrate another deployment-related change into their lives.

Sustainment Stage

The *sustainment stage* lasts from the end of the first month of the deployment to the month prior to return home. Sustainment is a time of establishing new sources of support and new routines. At home, many Army families rely on the local family readiness group (FRG), a garrison-based function that serves as a close network of community spouses and families. The FRG ideally meets on a regular basis to provide help with problems and disseminate information. The Army's sister services have groups that perform similar functions. In addition, many military spouses are comfortable receiving support from their families, friends, churches, or other cultural, community, ethnic, or religious institutions as their primary means of emotional support. As challenges occur, most spouses find that they are able to cope with crises and make important decisions on their own. They report feeling more confident and in control. During the sustainment stage, most military spouses report that they can do what is needed to keep their families functioning successfully.

Frequency, method, and content of communication between deployed service members and families are important factors at every stage of deployment, but especially during sustainment. The reality that phone contact is unscheduled and initiated by the service member can be frustrating. Spouses can feel tied to the house, not wanting to miss a call. Service members may feel forgotten if they call and no one is home, especially if they waited a long time to get to a phone. When expectations regarding the frequency of calls are unmet, resentment and anger may result. The Defense Satellite Network (DSN) offers time-limited calls home at no cost, depending upon location. Commercial phone lines are an option for some service members, but large phone bills can result, adding to family stress. More recently, some families are able to remain connected through video-teleconference capabilities via the Internet. For most military spouses, reconnecting with their loved ones is a stabilizing experience. For those who have difficult interactions during phone calls, the contact can exacerbate stress in the deployment stage and may result in the need for counseling.[9]

With e-mail now widely available, spouses and service members report feeling more in control; both are able to initiate communication, and they are not limited by the constraints of scheduling phone calls. Another advantage of e-mail is the ability to be more thoughtful about what is said and to monitor intense emotions that may be unnecessarily disturbing. However, e-mail security and restrictions can constrain some communication.

One disadvantage of the improved access to communication (phone calls or e-mail) is the immediacy of, and proximity to, unsettling news from either the family or the service member. It is virtually impossible to disguise negative feelings of hurt, anger, frustration and loss, especially on the phone. Inaccurate and disappointing news may travel quickly by personal cellular phones.

Unsubstantiated rumors can circulate unchecked within the FRG.[9] Rumors involving allegations of infidelity can be particularly damaging. Other troubling rumors may involve innuendo that a particular spouse or service member is handling the deployment poorly, combat accidents or injuries, unexpected changes in the date of return, or disciplinary actions. Rumors can be hurtful to service members, spouses, and the FRG. At its worst, unit cohesion and even mission success can suffer. Limiting the negative effect of rumors is a constant challenge for unit leaders and chaplains. The rapidity of crosscommunication of potentially inaccurate news can undermine the ability of the service member, unit, or family to focus and perform safely.

Late Deployment Stage

The *late deployment stage* is defined as the month before the service member returns home. Deployments occurring during the OIF surge have been marked by unexpected and late announced extensions of combat tours. Deployment extensions typically lead to frustration and anxiety for all involved and can introduce unexpected strain at a time when everyone is looking forward to the service member's return. The late deployment stage is generally one of great anticipation.

As in the deployment stage, there can be a rush of conflicting emotions: excitement that the soldier is coming home, apprehension, concern that spouses may not agree with how things have been managed, worry about whether independence will be lost or how roles will shift, and concern about whether family members will get along. With the separation almost over, there can be renewed difficulty making decisions. A spouse may wonder whether decisions should be deferred until the service member is home to make them. Many spouses also experience a burst of energy during this stage,[9,16] a rush to complete tasks around the home. During late deployment, expectations of service members, spouses, and children all are high.

Postdeployment

Postdeployment begins with the service member's return from theater and arrival home, sometimes first to the clearing station or demobilization station. Like predeployment, the time frame can be variable. The actual homecoming is often ceremonial and can be a joyous occasion. Children rush to the returning parent and the reunited couple embrace. The unit commander calls the unit to attention, praises unit members for their service, and then dismisses them. Weapons and equipment are turned in, and further demobilization tasks (including health evaluations, mental health surveys, and family health surveys) are completed. Finally, the family goes home. Homecoming can also be a frustrating and upsetting experience. The date of return may change, or units may travel home in separate groups over several days. Spouses may be required to attend to other unexpected family obligations, such as sick children.

A "honeymoon" period usually follows the homecoming, during which families reunite; however, they may soon find themselves feeling emotionally distant. Some spouses describe awkwardness in addition to excitement, especially reestablishing intimacy after so many months of separation. Emotional reconnection may require time before sexual intimacy feels comfortable. Eventually, returning service members reassert their role as spouse or parent within the family.[16] This is an essential task that can flow naturally or lead to tension within the family. Service members may feel pressure to make up for lost time and missed milestones. They may want to quickly reestablish the authority they had before. However, some things will have changed in their absence: spouses typically become more autonomous during deployments, children have grown, and individual personal priorities in life may be different. It is not realistic to expect everything to be the same as before the deployment.

During the postdeployment period, spouses may report a lost sense of independence or resentment at having been left on their own. Spouses may consider themselves to be the true heroes, who managed things while service members were away. At least one study[21] suggests that stay-at-home parents are more likely to report distress than the deployed service members. Like their military spouses, nondeployed spouses also have to adapt to changes that result from the homecoming, and may find they are more irritable with their mates around. They may desire to retain a sense of their own space. Basic household chores and routines need to be renegotiated. Roles played by each spouse in the marriage must be reestablished, perhaps in a new form.

Reunions with children can be both joyful and challenging. Youngsters' feelings tend to depend on their age and their understanding of the reason for the service member's absence. Babies less than 1 year old may not know the returned parent and cry when held. Toddlers (1–3 years) may be slow to warm up. Preschoolers (3–6 years) may feel guilty or scared about future separations. School-age children (6–12 years) may want a lot of attention. Teenagers (13–18 years) may be moody and may not appear to care. Children are often loyal to the parent who remained behind and may not respond initially to discipline from the returning service member. Children may also fear the military parent's return if a threat of discipline or consequences has been put forward. Some children may display ongoing anxiety triggered by the real possibility of future deployments. The returned service member may not agree with privileges granted to children by the nondeployed parent. Generally, reunited parents should not make immediate changes, instead taking time to renegotiate family rules and norms. Otherwise, the service member risks invalidating the efforts of the nondeployed parent and alienating the children. Returning service members may feel hurt in response to a perceived ambivalent reception. Clearly, making changes slowly and allowing children to set the pace for reintegration can lead to a successful reunion.

Postdeployment is probably the most critical stage for service member, spouse, and children. Successful reintegration is aided by fostering patient communication, setting reasonable expectations, and taking time for family members to reacquaint.[9,16] Counseling may be required if the soldier is injured, returns with unrelenting psychiatric symptoms, or engages in health-risk behaviors such as excessive alcohol use or physical displays of anger. Nevertheless, the separation experienced during the deployment offers service member and spouse a chance to evaluate changes

within themselves and what direction they want their marriage to take. Postdeployment is both a difficult and joyful stage, and many military couples have reported that their relationship is stronger as a result.

EFFECTS OF DEPLOYMENT ON SPOUSES

Soon after the August 1990 announcement that the United States would send troops to the Persian Gulf, Rosen et al[22(p47)] were tasked to study the impact of deployment on service member and family well-being. They studied Army spouses to determine which group had the most difficulty coping during ODS/S. They identified three vulnerable groups: (1) enlisted spouses under 30 years of age, many of whom were Spanish speaking and many married to noncommissioned officers; (2) very young spouses of junior enlisted, especially those living off post; and (3) older, employed spouses who faced their own unique stresses.

In May 2003, Haas et al surveyed[23] pregnant military and civilian women in the antenatal clinic at the Naval Hospital Camp Lejeune to measure stress levels. Almost predictably, women whose partners were deployed and who already had more than one child at home reported higher levels of stress (up to eight times greater than those with no children at home) than their peers who were married to nondeployed military members.[23(p48)] Another study conducted in a southeastern Virginia Navy community looked at families whose service members deployed to the Mediterranean between 1989 and 1991.[24(p103)] The authors found that deployment associated with combat had the strongest effect on spouses, predisposing them to depression.

Not all military families are traditional in constellation; some are single-parent families and some are blended families. Although in past wars most deploying service members were men, this is no longer the case. In 1993, Birgenheier[25] (quoting data from Magnusson and Payne) noted that women comprised more than 10% of the military, and that 14% of them, along with 4% of military service men, were single parents. With the onset of Operation Desert Storm on January 15, 1991, mothers were assigned to combat settings for the first time.[25(p471)]

CHILDREN'S DEVELOPMENTAL RESPONSES DURING DEPLOYMENT

Forty percent of service members have children, approximately one third of whom are less than 5 years of age. Children of varying ages respond differently to deployment stress. Their strengths and vulnerabilities are determined by stages of psychosocial development. Parents or other caring adults must avoid burdening children of any age with matters that are more appropriate to adults.

Some children may have greater difficulty adapting to the stress of a deployed parent. Signs or symptoms indicating an inability to return to normal routines or the presence of more serious problems require a visit to the family doctor or mental health counselor. Despite obstacles, the vast majority of spouses and children successfully negotiate the sustainment stage and look forward to their deployed family member coming home. Table 30-1 provides examples of negative behavioral and emotional changes in children of different ages that require further attention.

Infants

Infants (< 1 year; the Eriksonian psychosocial developmental stage of "trust versus mistrust"[26]) thrive when held and actively nurtured. The infant is at risk when a primary caregiver becomes significantly depressed or otherwise emotionally unavailable. Infantile depression may present with symptoms of apathy, irritability, eating refusal, or weight loss. Early intervention becomes critical to prevent undue harm or neglect. In particular, pediatricians should monitor growth. Personnel in community services, social work, pediatrics, and psychiatry must assist with parental support and treatment, parental skill development, and coordination of appropriate family services.

Toddlers

Toddlers (1–3 years; the Eriksonian psychosocial developmental stage of "autonomy versus shame,"[26]) generally take their emotional and behavioral cues from their primary caregivers. If the home-based parent is coping well, the toddler tends to do well. The opposite is also true. If the primary caregiver is not coping well, then toddlers may become sullen or tearful, throw tantrums, or develop sleep or eating disturbances. Toddlers respond to increased attention such as playing together, hugs, or longer bedtime rituals. Given the challenges of caring for young, active children, home-based parents should balance the demands for caring for children alone with their own needs for time. Parents may also benefit from sharing their day-to-day experiences with other parents facing similar challenges.

Preschoolers

Preschoolers (3–5/6 years; the Eriksonian psychosocial developmental stage of "initiative versus guilt,"[26]) may regress in acquired skills as a result of deployment stress. This regression may manifest itself as loss of toilet training, change in language use, thumb sucking, refusal to sleep alone, or increased neediness. Young children may become more irritable, depressed, or aggressive. They are prone to somatic complaints and can develop more pervasive fears of losing parents or other important adults. Caregivers need to reassure preschoolers with extra attention and physical closeness (hugs, holding hands). Adults should avoid changing family routines; they should support developmental accomplishments, such as encouraging youngsters to continue to sleep in their own bed. Answers to questions about the deployment should be brief, matter-of-fact, and to the point. Consistency of routines and expectations, although important for all age groups, provides greater comfort and security for younger children in particular.

School-Age Children

School-age children (6–12 years; the Eriksonian psychosocial developmental stage of "industry versus inferiority,"[26]) may whine and complain, develop somatic complaints, become aggressive, or otherwise behaviorally demonstrate their feelings. They may focus on the military parent missing a key event such as a birthday, school play, or important game. Depressive symptoms may present as sleep disturbance, loss of interest in school, changes in eating habits, or decreased desire to play with friends. School-age children benefit from talking about their feelings and need more physical attention than usual. Although some reduction in school performance may occur, parental expectations and routines should largely remain the same.

Rosen et al[27] studied children's responses during ODS/S deployments, finding that sadness was fairly widespread in both boys and girls aged 3 to 12 years old. Children's symptoms sometimes varied with birth order. Discipline problems and immature behaviors were more prominent in eldest children (mean age 7.2 +/− 5.4 years). Academic problems and refusing to talk were noted more in second children. Both groups evidenced eating and sleeping problems as well as increased need for adult attention.[27(p466)] Kelley[24] reported that the children of ODS/S combat-deployed service members demonstrated more internalizing and externalizing behaviors that took longer to resolve after the father's return. The frequently quoted study by Jensen et al[28] focused on children's responses to parental separation during ODS/S. In this study, ODS/S combat deployments were related to elevated, but not pathological, depressive and anxiety symptoms for both the nondeployed spouse and the children, as measured by parental reports. Boys and younger children appeared especially vulnerable to deployment effects.[28]

Adolescents

Adolescents (13–18 years; the Eriksonian psychosocial developmental stage of "identity versus role confusion,"[26]) may be irritable or rebellious. Teens might argue or participate in other attention-getting behavior. Huebner and Mancini[29] noted that adolescents face a number of normal developmental stressors, including puberty. These normal stressors combined with the multiple challenges of deployment can push teenagers' coping capacities beyond their limits. With their developing cognitive capacity for abstract thought and more complex emotional lives, adolescents may experience ambivalent feelings, such as anger mixed with pride in the deployed parent. They can also experience a sense of loss and uncertainty about whether they will see the parent again.

Changes in responsibilities and roles during deployment may be challenging, but also provide older children and teens with an opportunity for greater independence and growth. The return of the deployed parent can be more difficult due to the potential loss of these newly earned responsibilities. In Huebner's study, teens were more aware of having become closer to their nondeployed parents (mothers) and struggled to return to their previous roles and relationships at the end of the deployment. These adolescents also reported being aware of more intense family relations and of their own fluctuating emotions.[29(pp3,9,10)]

During parental deployments, adolescents may show a lack of interest in school, peers, and school activities. They are at greater risk for promiscuity, alcohol use, and drug use. Although teens may deny problems and worries, it is extremely important for caregivers to stay engaged and be available to talk about the teens' concerns. Sports and peer or family social activities should be encouraged to give normal structure to teens' lives. Academic tasks can add further order to a teenager's life. Likewise, additional responsibility in the family, commensurate with their emotional maturity, helps teens feel important and needed. Monetary incentives can also contribute positively to the maintenance of grades and chores. Adolescents should not, however, be placed in roles of coparenting or serve as confidantes

to the nondeployed spouse. Even the most capable adolescents need to know that competent adults remain in charge and will look after and care for the adolescents' needs.

INTERGENERATIONAL TRANSMISSION OF THE EFFECTS OF WAR AND COMBAT TRAUMA

Newer research has identified elevated rates of PTSD and depression in service members returning from combat deployment in Iraq, with approximately 20% of these personnel evidencing symptoms indicative of a mental disorder.[30] It is essential to consider the impact of these postcombat conditions on families, particularly children. Intergenerational trauma transmission, sometimes referred to as secondary traumatization, is a phenomenon whereby children are affected by their parent's posttraumatic sequelae.[31] A body of literature in this field has emerged since the mid-1960s, when the subject was first considered in work with families of Holocaust survivors.[32] Interest in the subject continued with the 1983 National Vietnam Veterans Readjustment Study (NVVRS), which was established in response to a congressional mandate for an investigation of PTSD and other postwar psychological problems among Vietnam veterans.[33] Numerous studies were conducted with families of Vietnam veterans that examined the psychological, behavioral, and adaptive styles of children of veterans. Additional work in the field of intergenerational trauma studies has focused on the impact of multiple traumas (genocide, political violence, repressive regimes, domestic violence, crime, and life-threatening diseases)[34] on survivor's children. In such cases, the children did not experience the actual traumatic events, but were affected by their parents' traumatic experiences.

The multigenerational repercussions of trauma are well documented in anecdotal data. Children of Holocaust survivors report feeling that they have absorbed their parents' Holocaust experiences as if "through osmosis."[35] Many children of Holocaust survivors describe an unspoken presence of the Holocaust in the home that served as an organizing force underlying family communications and relationships. Many reported that their parents never spoke about the traumas they endured, giving rise to the term "conspiracy of silence."[35] This "conspiracy" refers to an avoidance of discussion within the family as well as within society at large of the horrors experienced by Holocaust survivors. This silence is regarded as a powerful means of transmission of the impact of the parental trauma.

Initial clinical observations in the 1960s noted significant anxiety, depression, and maladaptive behaviors in children of Holocaust survivors.[36] The early literature was generally presumptive of significant psychopathology, given the severity and duration of the traumatic experiences of the parents who had little opportunity to integrate their massive losses and traumatic experiences. Over time, these results were questioned because of methodological weaknesses and lack of reliable data.[37] Questions naturally arose about how to assess the meaning and impact of any parental trauma on a child. New interest developed in considering the strengths that parents confer to their children as a result of their histories of traumatization.[32]

Similarly, studies of children of Vietnam veterans present a range of findings and conclusions. Some reports indicate that children of veterans had difficulties in academic performance, peer relations, and affective coping, with general deficits in psychosocial functioning.[38] The NVVRS determined that on over 100 life-adjustment indices, the majority of Vietnam veterans successfully adjusted to postwar life with few symptoms of psychological disorders.[33] Other studies raised concerns over the adverse impact on children related to their fathers' combat-related PTSD, emotional numbing,[39] or participation in acts of abusive violence during combat.[40] Studies appearing in the literature by the mid-1980s suggested that children of fathers with PTSD were at increased risk for learning disabilities, aggression, depression, and hyperactivity.[41]

A significant factor in the emergence of intergenerational trauma transmission appears to be related to whether the veteran parent had, or did not have, symptoms of PTSD. NVVRS data indicate a relationship between PTSD and family disruption, as well as marital instability and child behavioral problems.[40] Parental feelings of detachment or inability to feel and express emotions were noted to carry over into the parenting relationship, possibly leading to behavioral problems in children. Significantly, affective avoidance and emotional numbing are most highly correlated with behavioral difficulties in children of veterans.[42] The literature also notes that veterans who have participated in abusive violence or atrocities see themselves as social outcasts and have difficulty trusting others. These views can contribute to increased family violence and difficulty with the formation of nurturing parenting bonds.[40]

Intergenerational trauma transmission appears to occur most significantly when second-generation children experience trauma themselves. Vietnam veterans who were sons of World War II veterans and who were diagnosed with PTSD had more severe and persistent symptoms than veterans whose parents had not

been exposed to combat. Problems for these Vietnam veterans emerged at the time of homecoming, with clashes in ideology between fathers who fought the "good war" and sons who fought an unpopular war. The lack of support for returning Vietnam veterans may have impeded the resolution of PTSD symptoms and facilitated the intergenerational transmission of combat-related trauma for those with veteran fathers.[43] Similarly, Israeli veterans of the 1982 Lebanon War who were sons of Holocaust survivors were also noted to have especially severe and persistent symptoms of PTSD compared with control groups, suggesting that intergenerational trauma transmission is more pronounced when the offspring experience personal traumas.[44]

A veteran's PTSD can affect children in a number of ways. The parent's reexperiencing of traumatic events can be sudden, intense, and vivid. These intrusions are very frightening to children, who do not understand what is happening. Children may worry about the parent's well-being, or the parent's ability to provide care for them. Parents with emotional numbing and who are "shut down" can seem remote and uninvolved to their children. The parent may seem uncaring, and the child may feel unloved. Symptoms of anxiety, hyperarousal, irritability, and low frustration tolerance can influence a child's sense of safety and can cause the child to question the parent's love.[33]

Children of combat veterans with PTSD have been observed to fall into three general response types: (1) the disengaged child, (2) the overidentified child, and (3) the rescuer child. While the disengaged child may become emotionally detached from family life, the overidentified child tries to become closer to the parent at the expense of age-appropriate activities and peer relationships. This child may experience flashbacks and nightmares that are similar to the veteran parent. The rescuer child, similar to the child of an alcoholic, tends to feel responsible for the parent's problems and guilty when things do not go well. This child takes on parental roles and responsibilities.[38]

Trauma involves a disruption of emotions, beliefs, and cognitions. The parent may return from combat with altered thoughts, feelings, and behaviors in the aftermath of a single traumatic event, or as a result of prolonged exposure to the intensity of the combat experience. There may be change in parents' fundamental sense of themselves as people, and in the way they view themselves within the context of society as well as within their interpersonal relationships. Issues of safety and trust can be deeply affected by trauma, reshaping an individual's beliefs about relationships and about the world at large.[37] Intergenerational transmission of the impact of parental trauma occurs when the parent's disrupted beliefs and assumptions are communicated to a child who has not experienced the trauma but who comes to internalize a set of feelings or beliefs that parallel those of the traumatized parent.

Mechanisms of intergenerational transmission of trauma described by Ancharoff and colleagues[37] include silence, overdisclosure, identification, and reenactment. In an environment of silence, the child experiences the impact of the parent's trauma affectively but in the absence of explanation or reassurance. The family sometimes colludes in avoiding difficult subjects or any trigger to the traumatized parent's symptoms. The child can have frightening fantasies about the parent's unspoken experience and feel anxious about provoking the parent's symptoms. Overdisclosure occurs when the parent reveals frightening or horrific details that the child cannot tolerate and that may cause the child to develop PTSD symptoms. Identification may occur when a child tries to connect emotionally with a parent who is otherwise withdrawn and unavailable. Reenactment occurs when family members are involved in reliving some aspect of a traumatic memory as a result of the parent's difficulty with separating the past from the present.[37]

Not all children develop emotional problems in the aftermath of the parent's combat experience or PTSD symptoms. However, when a child is expressing emotional problems at home or in school, a comprehensive assessment of the child's social and academic status is indicated. This assessment should include an evaluation of overall family functioning and patterns of communication.

Because trauma involves betrayal of trust, all trauma-related work must occur within a safe and trusting therapeutic relationship. Individual treatment may be needed prior to participation in family therapy. The goal of intervention is to help the family recognize its patterns of communication, to develop beliefs and behaviors that distinguish the past from the present, and to have an expanded range of responses.[37] The combat veteran or any survivor of trauma must find a way to integrate past experiences with the present reality in a way that feels meaningful and hopeful. If silence attests to an inability to integrate trauma,[34] then the therapeutic dialogue must skillfully address this silence because it disrupts a sense of continuity of self and experience. The therapist does not seek to elicit detailed descriptions of the parent's traumatic experiences. Rather, assisting the family to develop new interactive patterns through a more informed awareness of family communication patterns is an appropriate goal in addressing the intergenerational

transmission of the effects of combat trauma.

The emerging body of anecdotal and empirical literature suggests that interpersonal relationships are affected by the profoundly disruptive nature of trauma. The issues are highly complex; over the past 40 years researchers have sought to identify, qualify, and measure the impact of parental trauma on children. If trauma occurs, how does it occur and how does it affect future generations and manifest in these successive generations? However, over the years since ODS/S, service members and their families have had to adapt to a major shift in US foreign policy and in the role of the US military in extended multinational deployments. The Bosnian experience provided new insight into the different skills needed to minimize familial trauma. Research on ODS/S veterans has further added to knowledge of this subject. However, the multiple and lengthy combat deployments of OEF and OIF have posed new challenges for military service members, their families, and children. It is unclear to what degree the traumatic experiences of service members involved in OEF and OIF will impact their children. Family well-being is not only essential to mission success, but also to the future health of the military in its efforts to retain skilled military service members.[45,46]

SUMMARY

The military, Department of Veterans Affairs, and TRICARE civilian healthcare professionals must be prepared to support service members and their families through the five stages of deployment, and the sequelae that might result from service member combat exposure. Given the established 20% rate of mental illness in returning OIF veterans, the multigenerational effects of combat-related stress and trauma must be considered as a possible health effect of the current conflicts. Public and professional education efforts on these topics are essential for families to cope effectively with the deployment experience and seek help if problems develop. Additional research addressing the impact of deployment on service members and their families will better ensure that US military forces are prepared for the challenges of the next conflict.

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ATTACHMENT: RESOURCES FOR MILITARY FAMILIES

An important endeavor for military members and their families is navigating through the many resources available to help them through the deployment cycle. Although not an exhaustive list, this attachment includes a number of these resources and a synopsis of their purposes.

Organizations Supporting the Service Member and Military Family

Military OneSource

Military OneSource (available at: http://www.militaryonesource.com) is a service provided by the Department of Defense at no cost to active duty, National Guard, and reserve (regardless of activation status) soldiers and their families. The agency promotes multiple services such as help with childcare, personal finances, emotional support during deployments, relocation information, and resources needed for special circumstances. These services can be accessed by telephone, online, and face to face through private counseling with master's level consultants in the local community.

Information on Helping Military Children

The Department of Defense, in partnership with LIFELines organizations, provide a Web site as the department's official source of education information (available at: www.militarystudent.org). Its purpose is to better enable the children of military personnel, their parents, special needs families, military leaders, and educators deal with the various issues that face the military child by providing each group with access to information, tools, and resources from a central location. Ultimately, the aim is to enhance the educational and social well-being of all military children by increasing the understanding and awareness of how to meet their unique needs.

Educational Resources Available to Aid Bereaved Children and Their Families

The New York University Child Study Center created a Web site (available at: www.aboutourkids.org) dedicated to advancing the field of child mental health through evidence-based practice, science, and education. Using the search engine on the site to look up information on bereavement, users can gain access to a list of books on bereavement, war, terrorism, and tolerance targeted at children of all ages, parents, and professionals.

National Child Traumatic Stress Network Guideline on Managing Childhood Traumatic Grief

The National Child Traumatic Stress Network, a consortium of treatment and research centers across the United States, provides an online guideline (available at: http://www.nctsnet.org/nccts/nav.do?pid=hom_main). The network comprises 70 member centers—45 current grantees and 25 previous grantees —funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, through a congressional initiative—the Donald J Cohen National Child Traumatic Stress Initiative. This initiative recognizes the profound, destructive, and widespread impact of trauma on American children's lives and seeks to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events.

Department of Defense Military Assistance Program

The Military Assistance Program (available at: http://dod.mil/mapsite/) aims to provide information and interactive resources for assisting military families with relocation, money management, and job search at a new location.

Operation Special Delivery

Operation Special Delivery (available at: http://www.operationspecialdelivery.com) provides trained volunteer doulas for pregnant women whose husbands or partners have been severely injured or who have lost

their lives due to the current war on terror, or who will be deployed at the time they are due to give birth. The doulas are informational, emotional, and physical coaches, not medical providers.

SGT Mom's

SGT Mom's (available at: http://www.family-networks.org/military. cfm) is an interactive Web site created in 1996 and run by a military spouse who handles all e-mails, updates, and additions. It is not an official Department of Defense site and is not related to any official military organization. The Web site contains a communication forum, links to other sites, the latest news about military families, ways to support troops, and a question-and-answer section. SGT Mom's is "military life explained by a military wife."

The National Long Distance Relationship Building Institute (Dads at a Distance)

As stated on the homepage, the Dads at a Distance Web site (available at: http://www.daads.com) was created "to help fathers who are business travelers, military men, non-custodial fathers, airline pilots, travel guides, traveling salesmen, railroad workers, truckers, professional athletes, musicians, entertainers, actors, corporate executives, or any other fathers who have to be away from their children to maintain and strengthen their relationships with their children while they are away." The Web site provides tips for long-distance fathers, links to related Web sites, information on relevant products and books, and stories of long-distance fathering.

The Tragedy Assistance Program for Survivors

The Tragedy Assistance Program for Survivors, or TAPS (Available at: http://www.TAPS.org) was founded after the deaths of eight soldiers aboard an Army National Guard aircraft in November 1992. TAPS provides a support network for the surviving families of those who have died in service to America. To accomplish their mission, TAPS has experienced caseworkers who act as liaisons, assisting the family members in finding solutions to problems. TAPS' small professional staff and a large national volunteer network work hand-in-hand with federal, state, and private agencies in finding solutions to problems of surviving military families.

The Building Strong and Ready Families Program

This is a 2-day program that helps couples develop better communication skills, reinforced by a weekend retreat. Additional information is available at http://www.strongbonds.org/skins/strongbonds/display.aspx.

The PICK (Premarital Interpersonal Choices and Knowledge) a Partner Program

This program helps single soldiers make wise decisions when they choose mates.

Additional Phone Numbers and Web Sites

Army Military Family Research Institute: http://www.mfri.purdue.edu/pages/news/soldier_family_well_being.html
Army OneSource: 1-800-464-8107; http://www.armyonesource.com (User ID: army; Password: onesource)
Department of Veterans Affairs: http://www.va.gov
National Center for PTSD: http://www.ncptsd.org/
Deployment Health Clinical Center: 1-800-796-9699; http://www.pdhealth.mil
HOOAH4HEALTH—Deployment: http://www.hooah4health.com/deployment/default.htm
Institute of Medicine—Health of Veterans and Deployed Forces: http://veterans.iom.edu/
Operations Noble Eagle, Enduring Freedom, and Iraqi Freedom: http://www.odcsper.army.mil/default.asp?pageeid+37
Reserve Affairs—Mobilization and Demobilization: http://www.defenselink.mil/ra/html/mobilization.html
Veterans Benefits Administration: 1-800-827-1000
Veterans Health Administration: 1-800-222-8387